IN RE: NEW ENGLAND COMPOUNDING PHARMACY INC.

CONFIDENTIAL PERSONAL INJURY OR WRONGFUL DEATH CLAIM FACT SHEET

IMPORTANT - DO NOT FILE THIS DOCUMENT WITH THE COURT - SEE SPECIAL INSTRUCTIONS TITLED "NOTICE OF DEADLINES FOR FILING CLAIMS AND CLAIM PROCEDURES."

Please provide the following information **TO THE BEST OF YOUR ABILITY** for each individual making a claim about exposure to New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center ("NECC") products. ~~More information, including a list of NECC products, is available at http://www.cdc.gov/hai/outbreaks/meningitis-facilities-map.html and http://www.donlinrecano.com/necp. SEE SPECIAL INSTRUCTIONS ENTITLED "NOTICE OF DEADLINES FOR FILING CLAIMS AND CLAIMS PROCEDURES."~~ You will need to submit this Fact Sheet by _____ ~~2013~~2014, at 4:00 p.m. (prevailing Eastern Time) or within 60 days of filing your Complaint if you have not already filed it.

- "You" used in this Fact Sheet means the person who was exposed to NECC products.
- "Product" means any medication or solution compounded by NECC.
- In filling out any section or sub-section of this Fact Sheet, please submit additional sheets as necessary to provide complete information.
- If, at a later date, you learn that any of your responses are incomplete or incorrect, please submit that information as soon as you become aware of it. In addition, supplemental information and documentation will likely be requested after you submit this initial Fact Sheet.

In completing this Fact Sheet, you are considered to have done so under oath. You must provide information that is true and correct to the best of your knowledge, information, and belief. If information is not known, remembered, or available, please indicate that in the appropriate location.

~~After reviewing your Fact Sheet, additional information and documentation will likely be requested from you. Please contact the your attorney immediately if you need to correct any of your answers or can provide more complete information.~~ You may and should consult with your attorney regarding completing this Fact Sheet. IF YOU ARE NOT REPRESENTED BY COUNSEL OR OTHERWISE ARE UNABLE TO FURNISH ANY OF THE INFORMATION REQUESTED, PLEASE PROVIDE AS MUCH OF THE INFORMATION AS YOU CAN.

Please Do Not Contact the Court With Any Questions or for Additional Information

****

I. CASE INFORMATION

1. Name of person ~~on whose behalf a claim is being made~~who was injured or died (first, middle name or initial, last), including maiden or other names used:

_____

a. Were you (or the person identified above) administered the steroid methylprednisolone acetate?

☐ Yes ☐ No ☐ Do Not Know

b. Were you (or the person identified above) administered another NECC Product?

☐ Yes ☐ No ☐ Do Not Know

If yes, please identify: _____

2. Name of person signing this form, if different from above:

_____

a. Relationship of signer to party on behalf of whom claim is being made (such as spouse, parent, family member, adult child, guardian):

b. If the person completing this Fact Sheet is completing this questionnaire in a representative capacity (*e.g.*, on behalf of the estate of a deceased person or a minor) ("Representative"), please complete the following:

~~1. Representative's Social Security Number (***Last 4 digits ONLY***):~~

~~XXX-XX-_____.~~

1. ~~2.~~ Maiden or other names used or by which Representative has been known:

_____

2. ~~3.~~ Address~~:~~ of the Representative:

_____

_____

3. ~~4.~~ State which individual or estate the Representative is representing, and in what capacity the Representative is representing the individual or estate (guardian, administrator, executor, etc.)?

_____

4. ~~5.~~ If appointed as a Representative by a court, please identify the court:

_____

Date of Appointment: _____

5. ~~6.~~ What is the familial or other relationship between the Representative and the deceased or represented person, or person claimed to be injured? _____

_____

6. ~~7.~~ If the Representative is representing a decedent's estate, please state the date of death, the address where the decedent died, and the cause of death and attach a copy of the death certificate if available: _____

_____

_____

_____

3. Please check the injuries you sustained as a result of exposure to the NECC Product(s):

a. ☐ Death

b. ☐ Fungal Meningitis

c. ☐ Arachnoiditis (persistent nerve pain)

d. ☐ Phlegmon (persistent nerve pain at base of spine)

e. ☐ Osteomyelitis (infection in bone, including vertebral or diskitis)

f. ☐ Sacroiliitis (pain at base of spine)

g. ☐ Peripheral Joint Pain (at site of injection)

h. ☐ Septic Arthritis

i. ☐ Epidural Abscess

j. ☐ Stroke or stroke like symptoms (Cerebral Vascular Accident)

k. ☐ Lumbar Puncture (Spinal Tap), Subsequent Treatment

l. ☐ Lumbar Puncture (Spinal Tap), No Subsequent Treatment

m. ☐ Infection of any kind, describe if known:

n. ☐ Injection only, no symptoms or treatment

o. ☐ Other (describe): _____

(Attach additional sheets if necessary to describe.)

4. Was any lawsuit or civil action ~~started~~initiated based on your exposure to an NECC Product, including any claiming wrongful death or claiming on behalf of an estate or survivors?

☐ Yes ☐ No

If Yes, please state:

a. Case Caption:

_____

b. Court and Docket Number:

_____

c. Name, address, telephone number, fax number and e-mail address of attorney representing you, if you know:

Attorney Name: _____

Firm Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Email Address: _____

****The Rest of This Form Requests Information About The Person Exposed to the Product*****

~~**II. PERSONAL INFORMATION**~~

~~5. Maiden name and other names used or by which you have been known:~~

_____

~~6. Social Security Number (***Last 4 digits ONLY***): XXX-XX-_____~~

~~7. Date and Place of Birth:~~

_____

[Moved to part IV per PSC suggestion]

II. EMPLOYMENT INFORMATION

5. ~~8. Sex:~~ Are you claiming to have lost money for any reason in the past (*e.g.*, past lost wages) or will in the future (*e.g.*, lost earning capacity), other than for payments for medical care because of your injuries? ☐ ~~Male~~ Yes ☐ ~~Female~~ No

~~9. Driver's License Number and State Issuing License:~~ _____

~~10. Current address and date(s) when you lived at this address:~~

_____

_____

_____

~~11. Identify each address at which you have resided during the last TEN (10) years, and list when you started and stopped living at each one:~~

~~Address~~	~~Dates of Residence~~

~~12. Identify the highest level of education (high school, college, university or other educational institution) you have attended (even if not completed), the dates of attendance, courses of study pursued, and diplomas or degrees awarded:~~

~~Institution~~	~~Dates Attended~~	~~Course of Study~~	~~Diplomas or Degrees~~

~~13. Are you married? ☐ Yes ☐ No~~

~~14. As an adult, have you ever been convicted or plead guilty to a felony or a crime of fraud, dishonesty, or moral turpitude? ☐ Yes ☐ No If you answered "Yes," describe where, when and the felony and/or crime.~~ _____

_____

_____

_____

III. EMPLOYMENT INFORMATION

15. Are you making a claim for past lost wages or future lost earning capacity or other economic loss, other than for medical bills? ☐ Yes ☐ No

16. If you answered "Yes" to Question 15 or you are not sure, then answer the next three questions.

6. If you answered "Yes" to Question 5 or you are not sure, then answer the next three questions.

a. Current employer (if not currently employed, last employer):

Name	Address	Dates of Employment	Occupation/JobTitle Duties

b. List the following for each employer you have had in the last TEN (10) yearssince January 1, 2004:

Name	Address	Dates of Employment	Occupation/Job DutiesTitle

7. 17. Are you making a wage loss claim for either your present or previous employment? ☐ Yes ☐ No?

If you claim to have lost more than $25,000 in your response to Question 5, answered "Yes," please provide:

a. Your annual income at the time of the injury/injuries alleged above to have been caused by your exposure to the NECC Product: _____

b. Your annual income presently: _____

c. The total amount of gross income you claim to have lost as a result of injuries you associate with your exposure to the NECC Product: _____. If ongoing, please so state.

d. ~~A narrative description of~~An explanation as to how you calculated the ~~total amount in Question 17c above:~~ amount you claim to have lost.

_____

_____

_____

e.

8. ~~18.~~ Have you ever served in the military, including the military reserve or national guard?

☐ Yes ☐ No

If you answered "Yes," answer the following question: Were you ever ~~rejected or~~ discharged from military service for any reason? ☐ Yes ☐ No If you answered "yes," and the discharge was anything other than honorable discharge, to the best of your knowledge please state the reason for your ~~rejection or~~ discharge:

_____

_____

III.~~IV.~~ INSURANCE/DISABILITY

9. ~~19.~~ Have you ever ~~filed~~received a social security disability (SSI or SSD) ~~claim~~award for a permanent disability? ☐ Yes ☐ No

If you answered "Yes," to the best of your knowledge please state:

Year claim was filed: _____

_____

Nature of disability: _____

Approximate period of disability: _____

10. In the last ten years, have you received short-term disability benefits for a period of more than 60 days or applied for long-term social security disability (SSI or SSD) benefits? ☐ Yes ☐ No

If you answered "Yes," to the best of your knowledge please state:

Year claim was filed: _____

_____

Nature of disability: _____

Approximate period of disability: _____

11. Have you filed a disability claim with any local/state/federal agency? ☐ Yes ☐ No

If Yes, when? _____

12. ~~20.~~ Have you filed a disability claim with any private insurance company ~~or local/state/federal agency~~? ☐ Yes ☐ No

If Yes, when? _____

13. ~~21.~~ Have you ever filed a worker's compensation claim? ☐ Yes ☐ No If you answered "Yes," to the best of your knowledge please state:

Year claim was filed: _____

_____

Nature of claim: _____

Approximate period of disability: _____

~~22. In the last 10 years, have you been out of work for more than 30 days for reason related to your health (other than pregnancy)? ☐ Yes ☐ No If you answered "Yes," set forth when and the reason.~~ _____

14.

15. ~~23.~~ Other than the present suit, have you ever filed a lawsuit or in the last ten years settled or made a ~~claim~~written demand for payment relating to ~~any~~a claim for bodily injury? ☐ Yes ☐ No If you answered "Yes," state to the best of your knowledge the court in which such action was filed, case name and/or names of adverse parties, and a brief description of the claims asserted. _____

_____

_____

_____

_____

16. ~~24.~~ Did you have medical insurance for treatment rendered ~~in this case~~as a result of your exposure to any NECC recalled product?

☐ Yes ☐ No

a. If Yes, please provide the following information for each insurance company. If more than one, please provide information for all:

Name of Health Insurance and/or coordinator of benefits~~/plan administrator~~:

_____

Policy Number: _____

Name of Subscriber: _____

b. If you have Medicare or Medicaid coverage, please state your ID number:

_____

c. Has any insurance company asserted a lien on your recovery?

☐ Yes ☐ No ☐ Don't know

If Yes, please provide the name and address of the ~~lienholder~~entity asserting the lienr: ___

_____

IV.~~V.~~ BACKGROUND AND FAMILY INFORMATION

17. Maiden name and other names used or by which you have been known:

_____

18. Social Security Number (***Last 4 digits ONLY***): XXX-XX-_____ [Note that we will need the entire SSN either on this form or in a separate document that accompanies it.]

19. Date and Place of Birth:

_____

20. Sex: ☐ Male ☐ Female

21. Driver's License Number and State Issuing License: _____

22. Identify your current address and each address at which you have resided since January 1, 2004, and list when you started and stopped living at each one:

Address	**Dates of Residence**

23. Identify the highest level of education (high school, college, university or other educational institution) you have attended (even if not completed), the dates of attendance, courses of study pursued, and diplomas or degrees awarded:

Institution	Dates Attended	Course of Study	Diplomas or Degrees

24. As an adult, have you ever been convicted or plead guilty to a felony or a crime of fraud, dishonesty, or moral turpitude? ☐ Yes ☐ No If you answered "Yes," describe where, when and the felony and/or crime. _____

25. Are you married? ☐ Yes ☐ No.

26. ~~25.~~ List ~~for each marriage~~ the name of your spouse; spouse's date of birth ~~(for your current spouse only)~~; spouse's current employer and occupation; date of marriage~~; date the marriage ended, if applicable; and how the marriage ended (*e.g.*, divorce, annulment, death)~~: _____

27. ~~26.~~ Has your spouse or any other family member filed a loss of consortium claim in this action?

☐ Yes ☐ No If you answered "Yes," state the name of your spouse or family member(s) filing the loss of consortium claim and their relationship to you. _____

28. If applicable, for each of your children, list his/her name and age. _____

29. ~~27.~~ To the best of your knowledge, has any child, parent, sibling or grandparent of yours been diagnosed with any form of immune disorder (*e.g.*, HIV, AIDS,) or auto-immune disorder (Crohn's disease, lupus, etc.)? ☐ Yes ☐ No If you answered "Yes," identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Disease: _____

If Applicable, Cause of Death: _____

30. ~~28.~~ To the best of your knowledge, did any child, parent, sibling, or grandparent of yours suffer from any of the following: arthritis/joint pain, chronic pain, diabetes, heart attack, cardiac disease, high cholesterol, high blood pressure, blood clots, coronary artery disease, congestive heart failure, deep vein thrombosis, vascular disease, transient ischemic attack, or stroke?

☐ Yes ☐ No ☐ Don't Know If you answered "Yes," identify each such person below and provide the information requested.

Name: _____

Current Age (or Age at Death): _____

Type of Problem: _____

If Applicable, Cause of Death: _____

~~29. If applicable, for each of your children, list his/her name, age and address:~~

If the person who was allegedly injured as a result of being exposed to the NECC Product is deceased, list any and all heirs of the decedent:

_____

_____

_____

31. ~~30.~~ Are there persons (other than those already identified in this Fact Sheet) you believe are witnesses to your claimed injuries or the damages? If so, please provide their name(s) and address(es):

_____

_____

_____

_____

V.~~VI.~~ MEDICAL INFORMATION

32. ~~31.~~ Date(s) you were administered or used an NECC Product:

_____

33. ~~32.~~ Hospital/clinic/physician's office where you were administered the NECC Product:

Name:_____

Full Address:

_____

_____

_____

34. ~~33.~~ Physician(s) who administered the NECC Product:

Name: _____

Full Address:

_____

_____

_____

35. ~~34.~~ What medical condition(s) did you have for which you were treated with the NECC Product (for example, osteoarthritis, back injury, etc.)?

_____

36. ~~35.~~ Identify your treating physician for the condition(s) in the preceding question if that physician is different from the one who administered the NECC Product:

Name: _____

Full Address: _____

_____

_____

37. ~~36.~~ Have you received other steroid injections with products manufactured or compounded by entities other than NECC? ☐ Yes ☐ No If you answered "Yes," state the product(s) and~~, if known,~~ the entities which manufactured or compounded the products:_____

_____

38. ~~37.~~ If you claim to have experienced symptoms or injuries from the administration of the NECC Product, when did you first experience symptoms and what symptoms did you have?_____

_____

39. ~~38.~~ Have you been tested for meningitis or fungal infection? ☐ Yes ☐ No

a. If Yes, provide:

1. Where? Name and full address of facility:_____

_____

_____

2. When? Date(s) of tests:

_____

3. Have you had a lumbar puncture/spinal tap since your exposure to an NECC Product? ☐ Yes ☐ No

40. ~~39. Who, if anyone, diagnosed your condition(s) that you claim is associated with your exposure to an NECC Product? If you identify anyone in response to this question, please identify that person by name and~~Has a doctor diagnosed any of the problems you listed in response to previous questions as caused by an NECC Product? If so, please identify the health care provider and when they diagnosed you as having suffered injury due to the NECC Product and provide his or her full address. full address: _____

_____

_____

41. ~~40.~~ Are any of the conditions you describe in response to Question 3 still affecting you? ☐ Yes ☐ No

If Yes, please describe: _____

_____

_____

42. ~~41.~~ Are you claiming that you have suffered or may develop bodily injury/injuries as a result of exposure to an NECC Product? ☐ Yes ☐ No If you answered "Yes," then please answer the following questions:

a. Who, if anyone, diagnosed your condition(s) that you claim is associated with your exposure to an NECC Product in Question 3? _____

_____

_____

b. Has any health care provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you identified in response to Question 3 are due to exposure to an NECC Product? ☐ Yes ☐ No If you answered "Yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told: _____

_____

2. Who told you (or your agents, representatives or anyone acting on your behalf) and when: _____

_____

3. Have you ever suffered this type of injury/injuries prior to the date set forth in answer to the prior question? ☐ Yes ☐ No If you answered "Yes," when and who diagnosed the condition(s) at that time? _____

_____

_____

_____

_____

43. ~~42.~~ Do you claim that your exposure to an NECC Product made a condition(s) or injury that you already had or had in the past worse? ☐ Yes ☐ No If you answered "Yes," set forth the injury or condition; state how you allege the NECC Product made the injury or condition worse; whether or not you had already recovered from that injury or condition before you were exposed to the NECC Product; and the date of recovery, if any. _____

_____

_____

_____

_____

44. ~~43.~~ Are you claiming mental and/or emotional damages as a consequence of exposure to the NECC Product?

☐ Yes ☐ No If you answered "Yes," for each provider (including, but not limited to a primary care physician, psychiatrist, psychologist, counselor, or therapist) from whom you have sought treatment for psychological, psychiatric, emotional, and/or marital problems ~~during the last TEN (10) years,~~ since January 1, 2004, state:

a. Name and address of each person who treated you: _____

_____

_____

_____

b. To your understanding, the condition(s) for which you were treated: _____

_____

_____

_____

c. When you were treated: _____

_____

d. Medications prescribed or recommended by provider: _____

_____

VI.~~VII.~~ COMMUNICATIONS WITH HEALTHCARE PROVIDERS

45. ~~44.~~ Do you remember any communication that you have had with a Healthcare Provider employee or representative related to the NECC Product?

☐ Yes ☐ No If you answered "Yes," please identify each employee or representative:

a. Who? _____

b. When? _____

c. To the best of your ability, please describe each communication with a Healthcare Provider employee(s) or representative(s) related to the NECC Product:

_____

_____

_____

_____
_____
_____
_____
_____

VII.~~VIII.~~ MEDICAL BACKGROUND

46. ~~45.~~ What is your ~~current~~ height? _____

47. ~~46.~~ What is your ~~current~~ weight? _____

48. ~~47.~~ Smoking/Tobacco Use History: Check the answer and fill in the blanks applicable to your history of smoking and/or tobacco use.

___ Never smoked cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
___ Past smoker of cigarettes/cigars/pipe tobacco or used chewing tobacco/snuff.
a. Date on which smoking/tobacco use ceased: _____
b. Amount smoked or used: on average _____ per day for _____ years.
___ Current smoker of cigarettes/cigars/pipe tobacco or user of chewing tobacco/snuff.
a. Amount smoked or used: on average _____ per day for _____ years.

49. ~~48.~~ Alcohol Use: Do you now drink or have you in the past TEN (10) years drunk alcohol (beer, wine, whiskey, etc.)? ☐ Yes ☐ No If you answered "Yes," fill in the appropriate blank with the number of drinks that represents your average alcohol consumption during the past TEN (10) years:

_____ drinks per day,
_____ drinks per week,
_____ drinks per month, ***or***

Other (describe): _____

50. ~~49.~~ Illicit Drugs: Have you used any illicit drugs of any kind (including injectable drugs) within one (1) year before, or any time after, you received an NECC Product? ☐ Yes ☐ No If you answered "Yes," identify each substance and state when you first and last used it. _____
_____
_____
_____

51. ~~50.~~ Have you been diagnosed with any form of immune disorder (including HIV/AIDS) or auto-immune disorder (including lupus, Inflammatory Bowel Syndrome, Crohn's disease, ulcerative colitis, mixed connective tissue disease)? ☐ Yes ☐ No If you answered "Yes," provide the following information:

Condition	~~When~~Date Diagnosed	~~Treating~~Diagnosing Physician	~~Hospital~~

Condition	~~When~~Date Diagnosed	~~Treating~~Diagnosing Physician	~~Hospital~~

52. ~~51.~~ To the best of your knowledge, ~~during the past TEN (10) years,~~since January 1, 2004, have you ever suffered from or been diagnosed by a doctor or other health care provider with:

		Yes	No	Don't Recall
a.	High cholesterol	___	___	___
b.	Hypertension/high blood pressure	___	___	___
c.	Obesity	___	___	___
d.	Diabetes	___	___	___
e.	Neuropathy	___	___	___
f.	Thyroid disorder	___	___	___
g.	Arthritis/joint pain	___	___	___
h.	Chronic pain	___	___	___
i.	Autoimmune disease (including HIV, AIDS, or Crohn's disease)	___	___	___
j.	Congestive heart failure	___	___	___
k.	Myocardial infarction (MI), heart attack, or other heart disease	___	___	___
l.	Stroke or transient ischemic attacks (TIAs)	___	___	___
m.	Chronic obstructive pulmonary disease (COPD) or other respiratory disorder	___	___	___
n.	Liver disease or jaundice	___	___	___
o.	Metabolic syndrome	___	___	___
p.	Enlarged prostate	___	___	___
q.	Arteriosclerosis (hardening of the arteries) or other vascular disease	___	___	___
r.	Osteomyelitis	___	___	___
s.	~~Abscess~~Spinal abscess	___	___	___
t.	Cirrhosis	___	___	___
u.	Hepatitis	___	___	___
v.	Kidney failure (end stage renal failure, dialysis)	___	___	___
~~t~~w.	Depression ~~or emotional issues requiring medication~~	___	___	___

If you answered "yes" to any of the conditions above, provide the following information for each condition:

Type of Condition	Date of Diagnosis	Diagnosing Doctor

53. ~~52.~~ Have you taken any of the following medications ~~over the last TEN (10) years~~since January 1, 2004:

		Yes	No	Don't Recall
a.	Insulin or glucose-lowering agents	___	___	___
b.	Narcotic pain relievers	___	___	___
c.	Analgesics	___	___	___
d.	Non-steroid anti-inflammatory agents	___	___	___
e.	Muscle relaxers	___	___	___
f.	Over-the-counter (non-prescribed) pain relievers	___	___	___
g.	Lipid-lowering agents (*e.g.*, statins)	___	___	___
h.	Disease-modifying agents (*e.g.*, monoclonal antibodies, such as Enbrel)	___	___	___
i.	Hypertension medications	___	___	___
j.	Insulin or other glucose lowering agents	___	___	___
k.	Steroids of any kind (including gluco-cortico steroids)	___	___	___
l.	Fungal medications (*e.g.*, methotrexate)	___	___	___
m.	Injectable products of any kind: Please specify: _____	___	___	___

54. ~~53.~~ Please list each ~~time you remember being hospitalized in the TEN (10) years~~hospitalization you have had since January 1, 2004:

Date	Name of Hospital	Reason for Hospitalization

~~VIII.~~IX. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

List the name and address of each of the following:

55. ~~54.~~ To the best of your ability, identify ~~your current~~each family and/or primary care physician ~~and each of your primary care physicians for the last TEN (10) years~~, as well as any doctor you have been treated by since January 1, 2004:

Name	Address	Approximate Treatment Dates

Name	Address	Approximate Treatment Dates

56. ~~55.~~ Each hospital, clinic, health care facility, or health care provider where you have received ~~inpatient or~~ outpatient treatment (including treatment in an emergency room) ~~during the last TEN (10) years~~since January 1, 2004:

Name	Address	Admission Dates	Reason for Admission

57. ~~56.~~ Each physician or health care provider from whom you have received treatment ~~in the last TEN (10) years~~since January 1, 2004 who is not otherwise identified in this Plaintiff Fact Sheet:

Name	Address	Dates of Treatment

58. ~~57.~~ Each pharmacy that has dispensed medication to you ~~in the last TEN (10) years~~since January 1, 2004:

Name	Address

Name	Address

IX.~~X.~~ DOCUMENTS

Please produce any of the following documents and things that are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers. Please attach all non-privileged documents and things to your responses to this Fact Sheet.

~~1. All documents you or anyone acting your behalf reviewed in preparation of this Fact Sheet.~~

1. ~~2.~~ Records of physicians, hospitals, pharmacies, and other healthcare providers identified in response to this Fact Sheet.

~~3. To the extent not included in the foregoing, all records relating to any examination of the individual exposed to the NECC Product by a physician or other health care provider, conducted for any purpose during the past TEN (10) years.~~

2. ~~4.~~ If this Fact Sheet was completed by a Representative, instruments or other documents authorizing or empowering the Representative to act on behalf of the person claiming injury.

3. ~~5.~~ Death certificate, if applicable, as requested above.

~~6. If the individual exposed to the NECC Product has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.~~

4. ~~7.~~ Copies of all documents from physicians, health care providers or others relating to the exposure to the NECC Product, or to any condition you claim is related to the exposure to the NECC Product.

5. ~~8.~~ All documents constituting, concerning or relating to product warnings or other materials provided to the individual exposed to the NECC Product or his or her agents, representatives or anyone acting on his or her behalf (other than those provided by your attorneys, or produced by the defendants in this case) in connection with the exposure to the NECC Product.

6. ~~9.~~ Any releases, covenants not to sue, or any other agreement(s) between you and any other person or entity relating in any way to the claims asserted in this lawsuit.

~~10. All press releases or other public statements made by or on behalf of you relating to this litigation.~~

7. ~~11.~~ All documents recording any communications concerning exposure to the NECC Product that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group, manufacturer or distributor, members of the press or news media, or other person.

~~12. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.~~

8. ~~13.~~ All documents relating to exposure or any alleged health risks or hazards related to exposure to the NECC Product in your possession at or before the time of the injury alleged in your Complaint (other than those produced by the defendants in this case).

~~14. All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant (other than those produced by the defendants in this case).~~

~~15. All photographs, drawings, journals, slides or videos relating to the injuries alleged in your Complaint.~~

~~16. If you are claiming lost wages or loss of earning capacity, any documents that refer, reflect, or relate to your past, present, or future earnings and earnings capacity, including but not limited to W-2s, 1099s, K-1s, tax returns, pay stubs, from the last 5 years.~~

~~17. All documents that record, reflect, or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the exposure NECC Product alleged in your Complaint.~~

~~18. Any diary entries, calendar entries, date book entries or other documents (including files maintained electronically) that reflect any alleged symptom, adverse reaction, or other injury resulting from the exposure to the NECC Product.~~

~~19. All documents referring or relating to any benefits, including, without limitation, Social Security disability benefits or any other disability benefits that you filed for, received, or were denied in connection with any injury or illness.~~

9. ~~20.~~ All documents in your possession, or in the possession of your attorneys, that you or your attorneys obtained directly or indirectly from the Defendants, other than documents produced by the Defendants in this litigation.

~~21. All documents in your possession, or in the possession of your attorneys, that you or your attorneys obtained directly or indirectly from any defendant in this case, other than documents produced in this litigation.~~

VERIFICATION

I declare under penalty of perjury that the information provided in this plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in this plaintiff's Fact Sheet, as required above.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respect incomplete or incorrect.

Signature:

_____

Print or Type Name:

_____

Document comparison by Workshare Compare on Friday, January 24, 2014 3:39:00 PM

Input:	
Document 1 ID	interwovenSite://US_DMS/US2012/53044693/2
Description	#53044693v2<US2012> - NECC Plaintiff's Fact Sheet
Document 2 ID	file://C:\Users\sj01269\Desktop\necc pfs ste clean.docx
Description	necc pfs ste clean
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	111
Deletions	172
Moved from	28
Moved to	28
Style change	0
Format changed	0
Total changes	339